

<p style="text-align: center;">Medical Direction / Trauma Systems EMSSTAR Workgroup – Meeting Notes</p>

August 17, 2005, 9:00 – 11:00 am
Maine Emergency Medical Services Office
500 Civic Center Drive
Augusta, Maine

Present:

John Brady, EMT-P, Portland Fire Department Medcu
Dan Carlow, Downeast EMS
Steve Corbin, Aroostook EMS
Steve Diaz, MD, Maine EMS
David Ettinger, MD, Mid-Coast EMS
Kevin Kendall, MD, Tri-County EMS
Paul Liebow, MD, Eastern Maine Medical Center
Paul Marcolini, EMT –P, Tri-County
Jim McKenney, EMT-P, Crown Ambulance
Julie Ontengo, Maine Medical Center
Rick Petrie, EMT-P, KVEMS and NEEMS
Rory Putnam, EMT-P, Falmouth Fire – EMS
Matt Sholl, MD, Maine Medical Center
Drexell White, Maine EMS

Not Present:

Bob Bowie, MD, St. Joseph's Hospital
Jay Bradshaw, Maine EMS
Jeff Cammack, Bangor Fire Department
Beth Collamore, MD, Cary Medical Center
Dawn Kinney, EMT-P, Maine EMS
Steve Leach, EMT-P, Augusta Fire and MCEMS
Lori Metayer, RN, EMT-P, LifeFlight of Maine
Chris Moretto, Med-Care Ambulance, Mexico
Carol Pillsbury, EMT-P, Northstar Ambulance

1. Introductions

- a. Group members introduced themselves and their affiliations.
- b. Randy Bumps reminded the workgroup that the primary purpose of this process is to provide a priority list of recommendations to the Maine EMS Board based on the EMSSTAR report. After Board action, a Maine EMS strategic plan will be drafted by others. Thus, the workgroup is not expected to do the detailed work of creating specific products. Instead, the expectation is that the workgroup will prioritize the recommendations of the

EMSSTAR report and identify any additional resources that could be utilized when the time comes later to develop specific products.

2. Review / approve notes from July 20, 2005 meeting

- a. No changes to the notes needed.

3. Review revised job descriptions as edited by Dr. Ettinger

- a. Dr. Ettinger distributed draft Service, Local and Regional Medical Director job descriptions as edited at the July meeting.
- b. The group first considered the Service level job description:
 - 1. Agreed it should be a “functional document with the bare minimums for training requirements.”
 - 2. Agreed goal is to “bridge the chasm between providers and doctors.”
 - 3. Change (I)(a) as follows: “Must be a provider in good standing with local hospital.” Eliminate all else.
 - 4. Change (I)(b) as follows: Add “physician or mid-level provider. ED provider is preferable. Community provider with 2 years of experience.”
 - 5. Change (II)(a) as follows: “...operation of Maine EMS systems and protocols.”
 - 6. Change (II)(c) as follows: “Knowledge of on-line medical control function.”
 - 7. Change (III)(d) as follows: “...issues initiated by someone in the public or someone else in the service...”
 - 8. Change (III)(g) as follows: Add “and be involved in and complete routine audits.”
 - 9. Concern regarding (III)(f) that insurance / liability issues, if any, be addressed to allow ride-alongs by the Service Medical Director.
- c. The group then considered the Local Medical Director job description:
 - 1. Question: Do we need this if we have good/qualified Service Medical Directors?
 - A: We’re more likely to have Local Medical Directors than Service Directors.
 - A: We see the Local Director as working between the Service and Regional Directors.
 - A: We can’t mandate Service Directors, therefore, Local Directors are the next “catch.”
 - A: The Local Director should be the “problem-solver / disciplinarian.”

2. With multiple hospitals in a region, who is the Local Medical Director?
A: One at each hospital.
 3. Will all hospitals agree to our job descriptions?
A: We're not necessarily going to the hospital and require it.
A: Job descriptions to be an advisory document to the hospitals.
 4. If Service Medical Director can't be retained, why not say that the Local Medical Director is the next "step?"
 5. Could we use past experience vs. contemporary experience to qualify?
A: Consensus to leave as drafted without "past" experience.
- d. The group agreed that all three job descriptions should be presented as recommendations.
 - e. The group agreed that when there are service and local medical directors we need to further define the differences between the roles no matter how similar the job descriptions appear.
 - f. The group moved to consider the Regional Medical Director Job Description:
 1. There was consensus on the Training portion as drafted.
 2. There was consensus on the Experience portion as drafted.
 3. Change (III)(c) as follows: "in the field" to "out of hospital."
 4. Change (III)(q) as follows: "must" to "should."
 5. Change (III)(r) as follows: remove "every month."

The group agreed that the job descriptions would not be edited further and that these revisions represented the group's final work on this recommendation.

4. Plan next meeting

- a. Agreed that Recommendations #4.8.3 "e" and "d" will top the agenda for the September meeting. (Require local and regional EMS medical directors to complete a nationally recognized medical directors' course within the first year of their appointment. And, develop and require appropriate training for any individual who will provide on-line medical direction to EMS providers.)
- b. Recommendation #4.9.3 "c" will follow. (Modify the Maine EMS Prehospital Treatment Protocols to authorize all EMS providers statewide to request air medical transport units without on-line medical direction.)

- 5. Next Meeting: September 21, 2005, 1-3 p.m., Maine Emergency Medical Services, 500 Civic Center Drive, Augusta, Maine.**